SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Medicaid Provider Fraud: Report for Proviso 33.17
April 1, 2018

The South Carolina Department of Health and Human Services (SCDHHS) engages in an on-going effort to prevent and identify fraud in the Medicaid program, and to recover the funds lost because of fraudulent and excessive practices on the part of healthcare providers. Not only is this mandated by federal regulations found in 42 CFR 455, it is even more critical because of the need to better manage scarce public resources in a time of rising demand and decreasing tax dollars. The department is committed to increasing the quality and number of cases referred to the SC Attorney General's Office for fraud and the recovery of funds lost due to fraud, waste and abuse.

The National Health Care Anti-Fraud Association estimates that financial losses due to health care fraud are in the tens of billions of dollars each year. Other estimates by government and law enforcement agencies such as the FBI place the loss due to health care fraud as high as 10 percent of annual health care expenditures. Federal regulations define fraud as "intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person." (42 CFR 455.2) Medicaid fraud is a criminal matter. Waste, improper claims, billing errors, and abuse also cause losses of Medicaid funds but are not criminal actions.

SCDHHS receives fraud "tips" from its fraud hotline and also conducts extensive data mining to identify potential fraud cases. Federal regulations require SCDHHS to conduct a preliminary investigation upon suspicion of fraud and then refer the cases to the Medicaid Fraud Control Unit (MFCU) in the SC Attorney General's Office. Cases are also referred to the MFCU from other sources, such as the FBI, the federal Office of Inspector General, other state agencies, and the MFCU's own fraud hotline. SCDHHS' Division of Program Integrity conducts these preliminary investigations and collaborates with the MFCU on all fraud cases. Fraud cases can take several years before final adjudication and the collection of any penalties or claim refunds by SCDHHS.

The MFCU also participates in national global cases that arise in connection with a U.S. Department of Justice investigation. Those cases oftentimes involve manipulation of wholesale drug prices by pharmaceutical companies to increase Medicaid payments. While considered fraud cases, they are prosecuted as civil cases as opposed to criminal cases. In calendar year 2017, eleven (11) settlements resulted from cases originating out of the National Association of Medicaid Fraud Control Unit (NAMFCU) actions resulting in recoveries of $8,702,390.08. The following table illustrates Medicaid provider fraud cases that were opened during calendar year 2017 and reflects the number of settlements and convictions that occurred during calendar year 2017. The percent of fraud cases referred by SCDHHS was 7%. Total 2017 calendar year recoveries were $11,001,212.82. Federal laws and regulations require the return of the federal share of Medicaid funds recovered. Approximately 68% of the recovered amount must be returned to the federal government. SCDHHS can retain the state share (approximately 32%) of the recoveries and re-use the funds to again match federal monies for the on-going operation of the Medicaid program.

PROVIDER FRAUD CASES	
New Provider Fraud Cases Opened*	**60**
Active*	**122**
Closed*	**70**
Number / % Referred by SCDHHS Program Integrity	**4 / 7%**
RESULTS	
Dollars recovered --Provider Fraud Convictions/Referrals[1]	**$1,077,334.58**
Dollars recovered -- All other PI cases[1,2]	**$1,221,488.16**
Total Number of Convictions	**13**
NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS (NAMFCU)	
Total number of cases settled**	**11**
Dollars recovered -- Global recoveries	**$8,702,390.08**

[1] All dollars shown are combined federal and state. Some of the recoveries in 2017 are from cases opened in prior year(s).

[2] Program Integrity recoveries due to cases for waste, overpayments, improper payments, and abuse that were not referred for potential fraud.

* Includes Globals
NAMFCU will typically appoint global case teams based on referral from the Department of Justice. The NAMFCU President appoints a global case team, generally consisting of three to four attorneys and an analyst, from the state MFCU. Global settlement agreements are negotiated by teams working in conjunction with the United States Department of Justice. The agreements are based on model language and resolve civil fraud allegations concerning the state Medicaid programs.

** Does Not Include Globals